

State of Montana REPORT OF EYE EXAMINATION Form 3

303 North Roberts Street PO Box 201430 Helena, MT 59620-1430 Out-of-state (406) 444-4590, FAX (406) 444-7623 In-State (406) 444-3273, FAX (406) 444-1631

					Please	Return Form To Patient	
PRINT FULL LEGNAME OF DRIVE	_				DATE OF BIRTH:		
SIGNATURE OF PERSON EXAMINED:					DRIVER'S		
ADDRESS:							
	()	Street)		(City)	(State)	(Zip)	
applicant is asked	d to visit an eye accurate measu rovement in vis al eye defects a eye specialist i st are requeste this form for th	e specialist when the sion would add are apparent as particularly valued. Driver licens e examination	licenses, and som n: eeded substantially to sa aluable if a driver's e examiners do no you conduct. Leav	ANATION FOR EYE SPECIALIST the drivers whose records cast doubt on the fety fitness is questioned in court or following to recommend or suggest physicians to a the blank any items not covered in your expenses.	ng an accident. In some ca applicants.	ases, examinations by more	
	·		·				
				a report from an eye specialist is accepts. For proper identification, have the particle.			
				RECORD OF EXAMINATION			
Distant Vision Only	Right Eye Only	Left Eye Only	Both Eyes Together	BREA	ADTH OF VISION FIELD		
With Present Glasses	20/	20/	20/	To Right of Point of Fixation		To Left of Point of Fixation	
Without Glasses	20/	20/	20/				
Best Possible Correction	20/	20/	20/	Total Angle			
Type of instrume	nt used to dete	rmine visual ac	uity:				
Are you fitting gla	asses for distar	nt vision?					
Is there double vi	ision?		If so, describe:				
Can it be correcte glasses?	ed with		By other tr	reatment?			
Are you undertak	ting such corre	ction or treatme	nt?				
Is there any evide	ence of eye dis	ease or injury?		If so, describe:			
Is there any unus	sual difficulty se	eeing in dim ligh	nt or at night?	If so, explain:			
·	•						
			CERT	TIFICATION OF EYE SPECIALIST			
l,				being licensed to practice in ophthalmo	ology, optometry in	,	
certify that I have presence.		nt Name) amined the eyes	s of the above-nar	ned patient, that this is a true record of t	(circle one) his examination and that h	(State) e or she signed this form in my	
SIGNATURE OF EYE SPECIALIS					DA	ATE:	

TELEPHONE

NUMBER: _

PHYSICIAN MEDICAL

NUMBER:

BUSINESS

ADDRESS: